Commentary to 'Surrogate decision-making in crisis.

***Thillagavathie Pillay [1,2,] Mona Noureldein[3] Manjit Kagla[4], Tracey Vanner[5], Deevena Chintala[3]**

[1]Neonatal Unit, University Hospitals of Leicester NHS Trust, Leicester, UK

[2]Academic Institute of Medicine, Faculty of Science and Engineering University of Wolverhampton, Wolverhampton, UK

[3]Post Graduate School of Paediatrics, West Midlands Deanery, West Midlands, UK**

[4]Legal Services, Royal Wolverhampton NHS Trust, Wolverhampton, UK

[5]Department of Obstetrics, New Cross Hospital, Royal Wolverhampton NHS Trust, Wolverhampton, UK

* Corresponding author

Correspondence: Neonatal Unit, University Hospitals Leicester, Level 2 Kensington Building, Infirmary Square, LE1 5WW. Telephone: 07791936718 fax: 01162585502 Email: tilly.pillay@uhl-tr.nhs.uk; tilly.pillay@nhs.net

ORCID: 0000 0002 4159 3282

** M Noureldein and D Chintala are Tier 2 trainees with the West Midlands Deanery

Funding source: none**.**

Acknowledgement: to neonatal and obstetric teams providing care, and to surrogate babies, their biological and intended families.

Competing interest: none

Ethical Approval: No ethical approval was required for this commentary.

Contributorship Statement: TP was responsible for initiating and developing the commentary. All authors contributed to the commentary, and approved the final version.

Data availability statement: there are no data in this commentary

Key words: Decision making, clinical ethics, neonatology, reproductive medicine

Word Count: 1005

Commentary to 'Surrogate decision-making in crisis' [1]

Abstract: In providing commentary to the case presented by DJC Wilkinson and T Pillay, we describe the uncertainties around complex decision making for the critically ill surrogate baby. We share our dilemma in recognizing that we, not the intended parents hold parental authority for Baby T. Despite this, we argue our case for compassionately including the intended parents in discussions and considering their perspectives in the complex decision making processes for Baby T.

Commentary to 'Surrogate decision-making in crisis' [1]

As clinicians this case [1] raises both personal and professional challenges.

A key issue is who carries legal parental responsibility for the difficult decisions that may be required around life-sustaining care in Baby T. Medico-legally, we understand that the surrogate mother (M) holds legal parental responsibility for Baby T until this can be transferred to the intended parents (IPs) [2]. But this process can take many months to complete, after the birth of baby (Figure 1). As M is now critically ill and unable to engage in any discussion around the care of her baby, who becomes the legal guardian of the baby, for complex decision-making that involves either a) re-orientation of care away from intensive care with the inevitable consequence of death in this extremely premature baby, or b) continuing this life-sustaining treatment with a high likelihood for major neonatal morbidity and longer term disability? Does it pass onto one of the IPs as the genetic father, or does this responsibility fall on the neonatal consultant managing the baby in intensive care? And if an antenatal surrogacy agreement had existed, is it legally binding for inclusion of the IPs perspectives in the decision-making, especially if our medical decision-making turns out to be at discord with the beliefs and wishes of the IPs for Baby T?

That M is the legal parent and retains birth right before legal parenthood can be assigned to the IPs, guides our concern. We argue that, on the premise that she has birth right [3], she has the right to be involved in decision-making around her baby after the

birth, despite any antenatal surrogacy plan, as these are non-legally binding [2]. With her being critically ill herself, we have no way of confirming that she would not have wanted to retain participation in decision-making around her ill baby after birth.

We also reflect that even where antenatal consent has been given by the surrogate mother for IPs to care for the baby immediately after birth, it is usual practice for the IPs to be *included* together with the surrogate mother in the decision-making process for the baby, with surrogate mother retaining overall responsibility until a parental order to the contrary is issued [2].

Our Trust legal perspective, from experience with similar cases, is that parental responsibility for Baby T lies with a) the surrogate mother or her husband or civil partner (Figure 2), and b) that one of the IPs could assume parental responsibility before the full surrogacy proceedings were completed, if he was the genetic father, and his name was declared as father on the birth certificate. But completion of the birth certificate requires the presence of M (Figure 2), and this is not possible immediately given the seriousness of M's condition. In the absence of this, the medico-legal responsibility for decision-making on care lies with the clinician in charge of her care, and not with the IPs [3].

While on Trust legal advice, we assume legal authority for complex decision-making around life-sustaining care for Baby T, this scenario poses further personal dilemmas for our team. For all sick babies we care for, parents are regularly updated regarding their baby's clinical condition. Complex decision-making around life-sustaining care involves intense discussions with parents and may include extended family members to support parents where relevant and societally appropriate. These are interwoven as part of the 'support' which teams provide for families, and each other, in dealing with such crises. Not being able to do this with M, or in her absence, the IPs, presents a substantial challenge to us, on compassionate grounds. We reflect on the importance of recognising the distress and anxiety faced by the IPs, who have engaged in the process of the surrogacy, have anticipated being the parents, and have an 'intention to care' for Baby T. In allowing the IPs to be at the bedside of Baby T, we *are* acknowledging their intent as parents/carers.

We feel a responsibility in three areas. The first is to make the most appropriate decisions around life-sustaining care for Baby T. The second, to consider the legal rights of her biological mother M, for when M does improve and should Baby T still be alive and requiring on going parental input for complex decision-making, before transfer of parenthood to the IPs. The third, is to support and include Baby T's IPs, who not unexpectedly would want to be included in the clinical updates for 'their baby' and potential plans and decisions for her. There is also the added responsibility of ensuring that the clinical team around Baby T, including those who would have regular contact with the IPs at the bedside, are equally supported through this difficult period.

We feel uncomfortable in not updating and including the IPs for Baby T in the decision-making process around life-sustaining care. We consider that quality of life and making a difficult treatment limiting decision [4] could not and should not be solely determined by us. Our care must be driven towards supporting the views of the IPs, with full clinical updates for Baby T as far as is possible. In the event that a discord were to emerge between decisions recommended by the clinical team and the IPs, and the surrogate mother continues to be indisposed, then we consider that legal recourse would need to been consolidated, but only as a last resort, after intense support and counselling with the IPs.

A current review of the surrogacy law with potential for offering legal parenthood to IPs from the moment of birth is being undertaken by the Law Commission UK [5]. If a revision is deemed appropriate, and the updated law *still* requires surrogate mother participation in the immediate decision/sign off after birth, the issues posed by this case will still remain, should the surrogate mother turn out to be critically ill after birth. We highlight this potential aspect to the Law Commission, to be considered in the development of the new guidance around legal parenthood and surrogacy.

Funding source: none**.**
Acknowledgement: to neonatal and obstetric teams providing care, and to surrogate babies, their biological and intended families.
Competing interest: none.
Ethical Approval: No ethical approval was required for this commentary.
Data availability statement: there are no data in this commentary.

References

1. Wilkinson DJC, Pillay T. Surrogate decision making in crisis. Journal of Medical Ethics, submitted December 2020, medethics2020-107181

2. Department of Health and Social Care. The Surrogacy Pathway. Surrogacy and the legal process for intended parents and surrogates in England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843890/Surrogacy_guidance_for_intended_parents_and_surrogates.pdf Accessed 16 December 2020

3. Oultram S. One mum too few: maternal status in host surrogate motherhood arrangements. Journal of Medical Ethics 2015;41:470-473

4. Brecht M, Wilkinson DJC. The outcome of treatment limitation discussions in newborns with brain injury. Archives of Disease in Childhood - Fetal and Neonatal Edition 2015;100:F155-F160

5. Law Commission. Reforming the Law. Surrogacy. https://www.lawcom.gov.uk/surrogacy/ Accessed 16 December 2020

6. Surrogacy: legal rights of parents and surrogates. https://www.gov.uk/legal-rights-when-using-surrogates-and-donors Accessed 16 December 2020

7. Surrogacy UK. https://surrogacyuk.org/ Accessed 16 December 2020

8. Cafcass. The parental order process. https://www.cafcass.gov.uk/grown-ups/parents-and-carers/surrogacy/ Accessed 16 December 2020

Table 1: Current Surrogacy Proceedings in the UK

Parental orders:

- A parental order reassigns parenthood, and transfers full parental responsibility from the surrogate parent/s to the intended parents
- Intended parents must apply for a parental order in all surrogacy cases
- To obtain a parental order, all of the following must be met:

1. *The Intended Parents*:
   - both be over 18
   - be married, civil partners or living together in an enduring family relationship
   - at least one of them must be a biological parent of the child
   - at least one of them must be resident in a part of the UK territory
2. *The arrangement*:
   - the conception must have taken place artificially
   - the child must be living with the intended parents at the time of the application
   - the surrogate and her husband/ civil partner must fully and freely consent to making the order
   - the child must be at least 6 weeks old before the surrogate can validly give her consent
   - No more than reasonable expenses must have been paid, unless authorised by the court
3. *The application:*
   - the intended parents must submit their application for a parental order within 6 months of the child's birth
   - the intended parents must apply to a Family Proceedings Court in the first instance
4. *Once a parental order is made*:
   - a new birth certificate was issued for the child, naming the intended parents and replacing the original one
   - the intended mother cannot have full recognition as a parent unless they obtain a parental order

Table 1: Current Surrogacy Proceedings in the UK [2,6,7,8]. The Law Commission UK [5] is currently reviewing the decision on whether legal parenthood to intended parents can be effected immediately at the time of birth of the baby.

Table 2: Current Surrogacy Law in the UK

Surrogate Mother's rights:

- The surrogate is treated as the legal mother and has the right to keep the child - even if she is not genetically related to the child
- Parenthood then can be transferred to the intended parents by a parental order or adoption
- UK law does not enforce the surrogacy agreements, even if an agreement has been signed between a surrogate mother and the intended parents

Surrogate's husband/ civil partner's rights:

- The surrogate's husband or civil partner is the child's legal father or second parent unless:
    - parenthood is transferred to another person through a parental order/adoption
    - the surrogate's husband or civil partner did not give their consent to their wife or partner for the surrogacy
- If a surrogate mother was not married but in a civil partnership, the child has no second parent/legal father unless the surrogate's partner actively agrees to be the second parent/legal father
- If the surrogate is not married or in a civil partnership at the time of conception, the intended father may be treated as the legal father at birth provided he signs the birth certificate with proof that he is the genetic father

Who goes on the birth certificate?

- The surrogate mother is responsible for registering the birth of her baby
- The surrogate mother is recorded as the child's mother on birth certificate
- The surrogate's husband or civil partner is recorded on the birth certificate as the father or second parent for same sex couples
- The intended father can be named on birth certificate if the surrogate mother is single. But, he must attend the birth registration in person together with the surrogate.

Table 2 legend: The current surrogacy law in the UK: [2,6,7,8]